



Cultural Diversity Series

Meeting the Mental Health Needs of African Americans

May 1999



National Technical Assistance Center for State Mental Health Planning
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 ♦ Telephone: (703) 739-9333
Fax: (703) 548-9517 ♦ Web site: <http://www.nasmhpd.org/ntac> ♦ E-mail: ntac@nasmhpd.org

MH02D5092



National Technical Assistance Center for State Mental Health Planning

Supported under Cooperative Agreement No. 1 U97 SM51944 between the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD).



Cultural Diversity Series

Meeting the Mental Health Needs of African Americans

May 1999

Prepared by:

National Technical Assistance Center for State Mental Health Planning (NTAC)

OMH-RC-Knowledge Center
5515 Security Lane, Suite 101
Rockville, MD 20852
1-800-444-6472

This publication was produced by the National Association of State Mental Health Program Directors (NASMHPD)/National Technical Assistance Center for State Mental Health Planning (NTAC) and is supported under Cooperative Agreement No. 1 UR1 SM52666-01 between the Division of State and Community Systems Development, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of State Mental Health Program Directors. Its content is solely the responsibility of the authors and does not necessarily represent the position of SAMHSA or its centers. ✓

Table of Contents

Acknowledgments	iii
Preface	iv
Introduction to the <i>Cultural Diversity Series</i>	1
♦ Disturbing Service Utilization Trends	1
♦ Cross-Cultural Mental Health Services and Barriers to Service Delivery	2
♦ Cultural Competence	4
♦ <i>A closer look at:</i> Refugees	6
♦ <i>A closer look at:</i> Non-English Speaking Consumers	7
African Americans	8
♦ Overview	8
♦ Unique Stressors, Unique Strengths	9
♦ Assessing Mental Health Service Utilization and Needs of African Americans	14
♦ Cultural Characteristics Affecting Use of Mental Health Services	18
♦ SMHA Strategies To Overcome Barriers	21
<i>Model Program: African American Family Services</i>	23
♦ Overview	23
♦ Cultural Perspective	23
♦ Services and Supports	24
♦ Funding	25
♦ Coordination and Accessibility	26
♦ Evaluation	26
♦ Contact Information	27
<i>Model Program: The Village</i>	28
♦ Overview	28
♦ Values	30
♦ Services and Supports	31
♦ Funding	32
♦ Coordination and Accessibility	32
♦ Evaluation	33
♦ Contact Information	34

Suggested Readings	35
Organizations	38
Web Sites	45

Acknowledgments

The National Technical Assistance Center for State Mental Health Planning (NTAC) wishes to acknowledge the efforts of a number of individuals who contributed their time and expertise to the development of this report. Contributing writers include: Richard Tyler, Ph.D., Clinical Director, African American Family Services (AAFS) and Salimah Majeed, L.I.C.S.W., Executive Director, AAFS. Susan R. McCarn, M.A., and Elaine R. Viccora, M.S.W., senior consultants with NTAC, are both contributing authors on this report and coordinators of the *Cultural Diversity Series*. Other NTAC staff who assisted with this report include John D. Kotler, M.S.J., Senior Writer/Editor; Andrea J. Sheerin, Information Specialist; and Rebecca G. Crocker, Design Specialist.

To ensure adequate and appropriate coverage of the concerns of ethnic and non-ethnic minorities, NTAC has made a commitment to have each report in the *Cultural Diversity Series* reviewed in draft form by experienced professionals and/or consumers who have expertise with the populations addressed in the specific report. We wish to particularly thank the following panel of reviewers for the African American report for their concise guidance and input: Mark Miller, M.C.D., Assistant to the Director, Missouri Department of Mental Health; Barbara Trout, Ph.D., Program Director, The Village Project; Oscar Morgan, Director, Maryland Mental Hygiene Administration; Roy Wilson, M.D., Director, Missouri Department of Mental Health; and Salimah Majeed, L.I.C.S.W., Executive Director, AAFS.

—Bruce D. Emery, M.Ed., M.S.W., Director

Preface

Public mental health systems must adapt to the changing U.S. population or risk becoming irrelevant in the health care marketplace of the future.

The National Technical Assistance Center for State Mental Health Planning (NTAC) is pleased to release the first installment in its *Cultural Diversity Series*, a group of technical assistance reports focusing on the mental health needs and access issues of diverse ethnic and non-ethnic populations. The increasingly heterogeneous composition of the U.S. population has important implications for the delivery of public mental health services, particularly for state mental health agencies (SMHAs). The *Cultural Diversity Series* is designed to facilitate a greater understanding of:

- ◆ the need for culturally competent mental health services;
- ◆ strategies for providing culturally competent mental health services and supports; and
- ◆ the resources necessary and available to develop culturally competent mental health services.

Public mental health systems must adapt to the changing U.S. population or risk becoming irrelevant in the health care marketplace of the future. Foremost, is the desire to provide high-quality mental health services equitably to all persons and groups. There are also compelling business reasons to incorporate cultural competence into state mental health systems. As mental health systems evolve under managed care, growing attention is devoted to contracting requirements and patients' rights. SMHAs face legal obligations to provide culturally appropriate services that may involve not only removing cultural barriers but also actively engaging clients from dozens of different ethnic backgrounds and a variety of other marginalized populations. SMHAs that ignore or minimize the racial, ethnic and cultural diversity of their clientele are likely to face serious liability issues in the future.

The task of becoming culturally competent is daunting, particularly given the growing number of cultural groups represented in this country. For example, Rhode Island, the smallest state in the nation, contracts with interpreters who speak 41 separate languages to accommodate its diverse population receiving human services.

While some biases may derive from bigoted attitudes and beliefs, others arise from a simple lack of knowledge and exposure to individuals from diverse groups. However, "small" behaviors often carry large consequences; misunderstandings sometimes result from unintended "insults"

based on miscommunication rather than lack of sensitivity. Training in cultural competence can help increase provider proficiency in communicating with consumers who have traditions and histories unfamiliar to the provider.

Despite the challenges, efforts to develop culturally competent mental health systems steadily continue. States are adopting a wide range of approaches, including creating specialized services for some ethnic and non-ethnic minorities, establishing linkages between the formal mental health system and traditional healers and community supports, and inviting community leaders to help guide the mental health system in its effort to improve services.

African Americans and the Mental Health System

The initial report of the *Cultural Diversity Series—Meeting the Mental Health Needs of African Americans*—focuses on the United States' largest ethnic minority group. The report provides a demographic and cultural overview of African Americans, discusses their mental health service needs, describes traditional patterns of service utilization and suggests strategies for enhancing access to effective, culturally competent mental health services. In addition, the report provides profiles of the following two model programs:

- ◆ African American Family Services (AAFS), a multifaceted, culturally-specific agency that provides mental health and substance abuse services in Minneapolis-St. Paul, MN.
- ◆ The Village Project, based in South Carolina's Charleston/Dorchester Community Mental Health Center, which provides a range of culturally competent mental health and support services to children and families.

The profiles describe the programs' philosophy and values, services and supports, funding sources and available evaluation data. Although a high percentage of those served by these culturally competent programs are African Americans, many of the programs' strategies are also applicable to consumers from other underserved or marginalized groups.

The authors of this report are keenly aware that significant differences exist among individuals and families who are members of any identifiable ethnic, racial and/or cultural group. Such differences may arise due to socioeconomic status, personal history, acculturation level for recent immigrants or numerous other variables. Individual characteristics must be recognized even as commonalities are acknowledged and respected. If they are not, mental health providers risk engaging in stereotypical thinking that overlooks and undermines consumers' individual needs.

Cultural Diversity Series

Future reports in the *Cultural Diversity Series* will focus on the mental health needs of Asians and Pacific Islanders, Hispanics/Latinos and Native Americans. As with this report, each successive technical assistance report will provide a synopsis of the particular population's mental health needs, including relevant cultural characteristics and traditions, perceptions about mental illness and preferences for services and supports. Each report will describe several mental health programs that have successfully tailored their services to meet the needs of ethnically and racially diverse consumers. The reports will also contain a comprehensive reference section, including lists of relevant readings, web sites and organizational resources. NTAC believes that the *Cultural Diversity Series* will provide important support to state mental health agencies, consumers, family members and state mental health planning and advisory councils as they seek to increase the cultural competence of their mental health systems.

In addition, NTAC will continue to support ongoing efforts by state mental health systems to expand cultural competency by developing two additional reports to be published in 1999: one on the mental health needs of gay, lesbian, bisexual and transgendered individuals and a second on the needs of persons who are deaf.

We invite readers to consider the importance of culturally competent mental health services through a careful review of this report. We look forward to receiving your candid comments and suggestions regarding this report's usefulness and to working with you to improve the quality of mental health care to diverse populations nationwide.

— Bruce D. Emery, M.Ed., M.S.W.

Introduction to the *Cultural Diversity Series*

The Cultural Diversity Series attempts to provide basic information and guidelines regarding the mental health needs of a variety of ethnic and non-ethnic minorities.

As the 21st century approaches, state mental health agencies (SMHAs) face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race and religion (ethnic-minority status) or age, disability, gender, sexual orientation or socio-economic standing (non-ethnic minority status)—challenges SMHA's to develop effective, culturally competent services and treatment methods. As the U.S. population changes dramatically, so does the SMHA consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27 percent) are non-white and/or Latino. By the year 2050, it is projected that nearly 1 in 2 Americans (47 percent) will be non-white and/or Latino.¹ Mental health staff may be unprepared for differences in language and world view, and even less prepared, for example, to support a gay inpatient consumer facing prejudice from other residents or to provide crisis intervention to a deaf or disabled consumer. However, local and/or federal statutes may require appropriate service provision to these persons.

The *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and non-ethnic minorities. Examples are provided of successful programs designed to meet the needs of specific populations. The goal is to assist SMHAs in moving toward mental health service delivery systems that are appropriate and accessible to all consumers.

Disturbing Service Utilization Trends

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Although utilization of mental health services varies among ethnic groups, research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later

¹ U.S. Bureau of the Census. (1996, May). *Resident Population of the United States: Middle Series Projection, 1996-2000 by Sex, Race and Hispanic Origin, with Median Age*. Washington, DC: Population Division, U.S. Bureau of the Census.

stages in their illness, thereby creating a need for more costly services.^{2 3} For example, studies have found that although African Americans, Native Americans and Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities.⁴

Little is known about the patterns of utilization of mental health services by sexual minorities (gay men, lesbians, bisexuals and transgendered persons). However, discrimination in mental health settings has been documented, as has the tendency of lesbian and gay youth (who are at high risk for substance abuse and suicide) to conceal their sexual orientation from health care providers.⁵ One major national survey found that 73 percent of lesbian respondents had pursued counseling services at some time, most frequently for feelings of sadness or depression.⁶

In anticipation of increased future service demands by growing ethnic minority populations, SMHAs are increasingly examining their accessibility to both ethnic and non-ethnic minorities. SMHAs may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent community-based services to all minorities, mental health decisionmakers can minimize human distress.

Cross-Cultural Mental Health Services and Barriers to Service Delivery

Culture encompasses "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious

² Lefley, H.P. (1990). "Culture and Chronic Mental Illness," *Hospital and Community Psychiatry* 41(3): 277-286.

³ Munoz, F. U., and Endo, R. (Eds.). (1982). *Perspectives on Minority Group Mental Health*. Washington, DC: University Press of America.

⁴ Aponte, H.J. (1994). *Bread & Spirit. Therapy with the New Poor: Diversity of Race, Culture and Values*. New York: W.W. Norton.

⁵ Gay, Lesbian, Bisexual and Transgender Health Access Project. (1997). *Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community*. (2nd Ed.). Boston: Massachusetts Department of Public Health.

⁶ Bradford, J., Ryan, C., and Rothblum, E.D. (1994). "National Lesbian Health Care Survey: Implications for Mental Health Care," *Journal of Consulting and Clinical Psychology* 62: 228-242.

or social group."⁷ Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus, the term "could be applied, for example, to a counseling dyad consisting of a low-acculturated Mexican American client and a high-acculturated Mexican American counselor."⁸ Similarly, a married heterosexual service provider brings a vastly different worldview and set of experiences to the counseling relationship than a single lesbian client. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, non-traditional healing practices and the role and desirability of medical intervention.^{9 10} Members of ethnic and non-ethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include:

- ◆ the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;
- ◆ lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
- ◆ consumer fears of experiencing discrimination in the treatment setting;
- ◆ mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices;
- ◆ language barriers increased by the growing numbers of both consumers and providers whose native language is not English;

⁷ Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs, M.R. (1989). *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Seriously Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Development Center.

⁸ Atkinson, D.R., Morten, G., and Sue, D.W. (1998). "Racial/Ethnic Minorities and Cross-Cultural Counseling." In Atkinson et al. (Eds.) *Counseling American Minorities*. New York: McGraw-Hill. p. 17.

⁹ Comas-Diaz, L., and Griffith, E.E. (Eds.). (1988). *Clinical Guidelines in Cross-Cultural Mental Health*. New York: Wiley.

¹⁰ Gaw, A.C. (Ed.). (1993). *Culture, Ethnicity and Mental Illness*. Washington, DC: American Psychiatric Press.

-
- ◆ communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;
 - ◆ lack of familiarity with Western or mainstream mental health services;
 - ◆ fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and
 - ◆ systemic barriers, such as funding sources that place strict limits on reimbursable services.

Special challenges may be present in the case of consumers who are refugees or whose native language is not English; both of these groups may exist within all of the communities addressed in the *Cultural Diversity Series*. For a fuller discussion of needs and barriers to service faced by consumers who are refugees or are non-English speaking, see the sidebars on pages 6-7.

Cultural Competence

Developing cultural competence within a mental health system is a dynamic and evolutionary process.¹¹ The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences and assessing the mental health system's success in addressing cultural differences. Cultivating cultural competence requires close scrutiny of each component of mental health services, including assessment, treatment and evaluation.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one's self; of unstated institutional cultural norms; and of the history, culture and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural heritage; to understand how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery; and to understand the significant impact of differences

¹¹ In *Building Bridges, Tools for Developing an Organization's Cultural Competence* (see suggested readings), the authors indentify six stages of developing cultural competence:

- Stage 1 Sees other cultures as inferior: seeks to destroy other cultures.
- Stage 2 Cultural incapacity: adopts paternalistic posture toward so-called inferior people.
- Stage 3 Cultural incapacity: seeks to assimilate differences, ignore strengths.
- Stage 4 Cultural precompetence: realizes weaknesses and makes commitment to improve.
- Stage 5 Culturally competent: respectful, accepting, self-monitoring.
- Stage 6 Takes advocacy and educational role.

both in language and in verbal and nonverbal styles on the process of communication.¹² Mental health systems typically operate on unstated Western principles—such as, for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body and devaluing of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subject of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of ethnic minorities, their mental health needs and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and to ask consumers how *they* understand their problems and what *they* need.

As mental health systems wrestle with the transition to managed care and other fundamental changes, it is essential that they also address the need for individualized, culturally competent services for ethnic and non-ethnic minorities. This report explores these issues and their implications for African American consumers.

¹²Atkinson et al., op. cit.

A closer look at: Refugees

People seeking refuge in the United States come from all ethnic and racial backgrounds and often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation and inability to return to their homeland.¹³ Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) which often accompany resettlement in a new country.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety and post-traumatic stress disorder are reported at disproportionately higher rates in refugee populations. In addition, a small percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture which may require prolonged, intensive intervention.¹⁴ Typically, SMHAs have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include:

- ◆ networking with and through the refugee community;
- ◆ conducting home visits;
- ◆ linking with physical health services;
- ◆ using bicultural professional and paraprofessional staff; and
- ◆ making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies or ethnic organizations that assist individual refugees upon arrival) and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

¹³ Garcia-Peltoniemi, R.E. "Clinical Manifestations of Psychopathology." In Westermeyer, J., Williams, C.L., and Nguyen, A.N. (Eds.) (1991). *Mental Health Services for Refugees*. Washington, DC: U.S. Government Printing Office.

¹⁴ Ibid.

A closer look at: Non-English Speaking Consumers

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with and treating non-English speaking and/or deaf consumers, who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including:

***Bilingual Paraprofessionals.** While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate and trainer of service providers about the refugee's culture.¹⁵ Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers and other mental health professionals.

Interpreters. Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and building of rapport between the mental health professional and interpreter."¹⁶ Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

**Persons who can communicate in a spoken language and in American Sign Language are considered bilingual.*

¹⁵ Egli, E. (1987). *The Role of Bilingual Workers Without Professional Mental Health Training in Mental Health Services for Refugees*. Minneapolis, MN: Department of Psychology, University of Minnesota.

¹⁶ Adkins, M.A. (1990). "Role of Bilingual/Bicultural Service Providers in the Delivery of Mental Health Services." In Holtman, W.H., and Bornemann, T.H. (Eds.) *Mental Health of Immigrants and Refugees - Proceedings of a Conference Sponsored by Hogg Foundation and World Federation for Mental Health*, Austin, TX: Hogg Foundation for Mental Health.

African Americans

Broad political, historical and sociological influences combine with traditionally organized service systems to create significant barriers to meeting the mental health needs of African Americans who may be unfamiliar with or distrustful of public systems.

Overview

African Americans, the nation's largest ethnic minority group, number nearly 34 million and comprise approximately 13 percent of the total U.S. population. People of African descent living in the United States are a diverse group. Although the majority of African Americans lived in the rural South during the early part of this century, successive waves of migration have changed that picture substantially. Between 1940 and 1970, more than 1.5 million African Americans migrated from the South to the North and West. Today 84 percent of Black Americans live in urban areas.¹⁷

As of 1998 there were 8.3 million African American families in the United States. Of these, 45 percent were families headed by married couples, and 46 percent were families maintained by women.¹⁸ There were 8.9 million African American children in the United States; 43 percent of these children live in families with married parents and 52 percent in families maintained by women. Of those in married couple families, 72 percent are raised in homes where both parents work.¹⁹

Due in part to recent immigration trends from Egypt, Ethiopia, Nigeria and Ghana as well as Haiti, Jamaica and other Caribbean nations, about 6 percent of African Americans are foreign

¹⁷Henderson, L. (1994). "African Americans in the Urban Milieu: Conditions, Trends, and Development Needs." In Tidwell, B. (Ed.) *The State of Black America*. New York: National Urban League.

¹⁸Bureau of Labor Statistics. (Unpublished). *Table 4: Families by type of family, employment status of members, presence of own children under 18 years old, race, and Hispanic origin, 1998 Annual Averages*. Washington, DC: U.S. Department of Labor.

¹⁹Bureau of Labor Statistics. (Unpublished). *Table 7: Number of own children under 18 years old in families by age of children, type of family, employment status of parents, race, and Hispanic origin, 1998 Annual Averages*. Washington, DC: U.S. Department of Labor.

born.²⁰ The differences in cultural beliefs, religions and linguistic heritage among African Americans make it incumbent on state mental health agencies (SMHAs) to avoid simplistic assumptions about African American consumers while also understanding common threads for providing culturally competent mental health services.²¹

Unique Stressors, Unique Strengths

Prejudice and Poverty

A heritage of chattel slavery, segregation, and racial prejudice provides obstacles that have burdened Black Americans and affected the development of Black American families. In addition to continuous pressures of racism and oppression, Black American families face contemporary threats to family stability. Such threats include poverty, widespread drug abuse, teenage pregnancy, communicable diseases, and violent crimes.²²

Many authors caution against naïve assumptions that racism no longer exists or does not have an impact on both the mental health needs and help-seeking behaviors of African Americans. In the chapter cited above, Wilson and Stith offer a cogent argument that an exclusive "here and now" focus in providing mental health services to African American families risks ignoring the critical impact of slavery, racism and institutionalized barriers to equality. A number of authors have discussed the effects of chronic social obstacles on the identity development of African American men,²³ and other authors have noted that black men have faced limited access to educational and employment opportunities and increased risk of contact with the judicial system, imprisonment or death by violent crime.²⁴

²⁰ U.S. Bureau of the Census, Public Information Office. (1998, January). *Census Bureau Facts for Features*. Washington, DC: U.S. Bureau of the Census.

²¹ NTAC recognizes the importance of language and self-identifying terms within a discussion of cultural competence. This report uses the terms African Americans and Black Americans interchangeably, as well as the term White Americans, often following the lead of the contributing writers.

²² Wilson, L.L., and Stith, S.M. (1998). "Culturally Sensitive Therapy With Black Clients." In Atkinson, D.R., Morten, G., and Sue, D.W. (Eds.) *Counseling American Minorities*. New York: McGraw-Hill. p. 116. (Reprinted from *Journal of Multicultural Counseling and Development*. (1991) 19:32-43.)

²³ Harris, S. (1998). "Psychosocial Development and Black Male Masculinity: Implications for Counseling Economically Disadvantaged African American Male Adolescents." In Atkinson et al. (Eds.), op. cit. (Reprinted from *Journal of Counseling and Development*. (1995). 73: 279-287.)

²⁴ Bethea, P.D. (1998) "African-American Women and the Male-Female Relationship Dilemma: A Counseling Perspective." In Atkinson et al. (Eds.), op. cit. (Reprinted from *Journal of Multicultural Counseling and Development*. (1995). 23:87-95.)

Negative pressures resulting from a history of racism exist both externally and within African American communities. Historically, for example, light-skinned African Americans may have received preferential treatment over dark-skinned African Americans—affecting both interracial and intra-racial conflicts. Wilson and Stith point out that "historical and current experiences of racism and prejudice seem to be an organizing and universal experience that link Black American families and that demands our attention."²⁵

It is common when working with African American consumers in the public mental health system to encounter issues of both race and class. Chronic, institutionalized barriers to equality and opportunity are among the many complex factors contributing to disproportionate numbers of African Americans living in poverty. However, it is important for providers to differentiate between ethnic identity and socioeconomic status. For example, African Americans and White Americans have been thought to experience different levels of psychological distress. However, some reviewing researchers have concluded that distress rates are not actually different when controlled for age, gender, marital status and, "most importantly, socioeconomic status."²⁶ Other researchers have concluded that African Americans do experience more stressors than White Americans, regardless of economic class, largely due to effects of oppression and minority group membership. In either case, socioeconomic factors as they affect African Americans are critical to consider in developing appropriate mental health services and supports. Statistics on income, employment and educational status underscore the challenges that many African Americans face. According to recent data:

- ◆ More than 26 percent of African Americans live below the poverty line, compared with 11 percent of White Americans.²⁷
- ◆ Per capita income of African Americans was \$12,351 in 1997, compared with \$20,425 for White Americans.²⁸
- ◆ Only 16.5 percent of African Americans held managerial and professional positions compared with 27.1 percent of White Americans who held such positions. In addition,

²⁵ Wilson and Stith, op. cit., p. 117.

²⁶ Lefley, H.P. (1994), cited in Atkinson et al., op cit., p. 56.

²⁷ U.S. Bureau of the Census, Public Information Office. (1998, September). *Number of African Americans in Poverty Declines While Income Rises, Census Bureau Reports*. Washington, DC: U.S. Bureau of the Census.

²⁸ Ibid.

22.9 percent of blacks held semi-skilled labor positions compared with 14.2 percent of whites.²⁹

- ◆ Black Americans have historically been behind their White American counterparts in terms of educational attainment. This gap, however, has narrowed in recent years. As of 1992, 67 percent of African Americans age 25 and older were high school graduates compared with 81 percent of whites; by 1998 these numbers had changed to 76 percent and 84 percent respectively. As of 1998, 15 percent of blacks had completed four or more years of college compared with 25 percent of whites.³⁰

Understanding that the impacts of poverty and prejudice on health and mental health are interconnected yet distinct is especially important for public mental health officials, whose most frequent clients are those who cannot afford privately funded care.

Health Related Stressors

A variety of health concerns differentially impact African Americans including, for example, high blood pressure and diabetes. Non-Hispanic African Americans are more likely than White Americans to suffer from high blood pressure; people with lower educational and income levels also tend to have higher blood pressure. In 1996 death rates from high blood pressure were approximately four times greater for African Americans than for White Americans.³¹ A large proportion of persons with diabetes have high blood pressure as well. Among non-Hispanic African Americans, 10.8 percent have diabetes; this rate is 1.7 times greater than for White Americans.³²

A more recent and less widely discussed stressor is significantly disproportionate rates of Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS). Although they represent only about 13 percent of the U.S. population, African Americans

²⁹ U. S. Bureau of the Census. (1990). *Detailed Population Characteristics*. U.S. Summary, Section A. Washington, DC: U.S. Government Printing Office.

³⁰ U.S. Bureau of the Census. (1998). Historical Tables, Table A-2: Percent of People 25 Years Old and Over Who Have Completed High School, Selected Years 1940 to 1998. Available at <http://www.census.gov/population/socdemo/education/tablea-02.txt>

³¹ American Heart Association. *High Blood Pressure Statistics*. Available at http://www.americanheart.org/Heart_and_Stroke_A_Z_Guide/hbps.html

³² National Institutes of Health. (1999). *Diabetes Statistics*. (NIH Publication No. 99-3926) Rockville, MD. Available at <http://www.niddk.nih.gov/health/diabetes/pubs/dmstats/dmstats.htm>

accounted for 45 percent of reported cases of AIDS in 1997.³³ As with other racial/ethnic groups, youth are at highest risk for HIV infection. In a study of HIV infection among 13-24 year olds, spanning 25 states between 1994 and 1997, 63 percent of HIV diagnoses reported were among African Americans.³⁴ In 1997, 60 percent of reported AIDS cases in women were among African Americans, as were 62 percent of pediatric AIDS cases.³⁵ As of 1996 (the year of the most recent available complete data), AIDS was the leading cause of death among African American women ages 25-44.³⁶ The Centers for Disease Control and Prevention (CDC) has stated that "the disproportionate impact of HIV/AIDS on African Americans underscores the importance of increasing prevention efforts in this community. HIV prevention efforts must take into account cultural issues as well as social and economic factors—such as poverty, underemployment and poor access to the health care system—that impact many U.S. minority communities."³⁷

Economic and Educational Advances

While cultivating an awareness of the social pressures facing African Americans, it is also important to rebut the stereotype that *all* African Americans are poor.³⁸ Indeed, according to the census data cited above, more than 70 percent of African Americans do *not* live in poverty. Examining changes in educational attainment within a recent age cohort reveals that among 25 to 29 year-olds, by 1997 there was no statistical difference in the rate of high school completion for African Americans and White Americans.³⁹ In 1997, 13.3 percent of African Americans over age 25 had earned a bachelor's degree or above; the median income for African Americans with

³³ Centers for Disease Control and Prevention. (1998). *Critical Need to Pay Attention to HIV Prevention for African Americans*. Available at <http://www.cdcnpin.org/geneva98/issues/fafram.htm>

³⁴ Ibid.

³⁵ Ibid.

³⁶ Centers for Disease Control and Prevention. (1998). *Critical Need to Pay Attention to HIV Prevention for Women: Minority and Young Women Bear Greatest Burden*. Available at <http://www.cdcnpin.org/geneva98/issues/fwomen.htm>

³⁷ Centers for Disease Control and Prevention. (1998). *Critical Need to Pay Attention to HIV Prevention for African Americans*. Available at <http://www.cdcnpin.org/geneva98/issues/fafram.htm>

³⁸ Atkinson et al., op. cit.

³⁹ U.S. Bureau of the Census. (1998). *Educational Attainment in the United States*. Washington, D.C.: U.S. Government Printing Office.

at least a bachelor's degree was \$31,898.⁴⁰ Atkinson, Morten and Sue point out that "while these figures trail those of European Americans with comparable educational levels, they demonstrate that although an unacceptable percent of African Americans live on incomes below the poverty level, there is a sizable portion of African Americans who live on middle-class incomes."⁴¹

Church and Family Supports

Two important coping resources and strengths in the African American community are strong family relationships and church supports. As Wilson and Stith observe: "Historical evidence suggests that strong family ties bound Black Americans together during the confusion that followed the Civil War. To adapt to pressures of slavery and discrimination, Black families developed the ability to persevere, organize, and succeed despite odds."⁴² Research suggests that family support is more important to African Americans than is any other type of support.^{43 44} Writers emphasize the supportive roles of the extended family, including "adoptive" kin and co-workers, and of black churches as an important social support network.^{45 46 47}

Both Christianity and Islam have been potent organizing forces in many African American communities, contributing, for example, profound leadership by significant religious figures during the civil rights movement. Many black churches retain a vibrant African-based "call and response" style of interactive worship. Research indicates that African Americans are more likely than White Americans to use prayer as a coping strategy.⁴⁸ This is especially true for African

⁴⁰ U.S. Bureau of the Census. (1999). Table 9: Total Money Income in 1997 of People 25 Years Old and Older, by Education, Region, and Race.

Available at <http://www.census.gov/population/socdemo/race/black/tabs98/tab09A.txt>

⁴¹ Atkinson et al., op. cit., p. 43.

⁴² Wilson and Stith, op. cit., p. 119.

⁴³ Cauce, A.M., Felner R.D., and Primavera, J. (1982). "Social Support in High Risk Adolescents: Structural Components and Adaptive Impact," *American Journal of Community Psychology*. 10: 417-428.

⁴⁴ Raymond J., Rhoads, D., and Raymond, R. (1980). "The Relative Impact of Family and Social Involvement on Chicano Mental Health," *American Journal of Community Psychology*. 5: 557-569.

⁴⁵ Lyles, M., and Carter, J. (1982). "Myths and Strengths of the Black Family: A Historical and Sociological Contribution to Family Therapy," *Journal of the National Medical Association* 74(22): 1119-1123.

⁴⁶ Wilson and Stith, op. cit.

⁴⁷ Boyd-Franklin, N. (1989). *Black Families in Therapy: A Multi Systems Approach*. New York: Guilford.

⁴⁸ Veroff, J., Douvan, E., and Kulka, R. (1981). *The Inner American: A Self Portrait from 1957-1976*. New York: Basic Books.

American women and older African Americans.⁴⁹ As the seriousness of problems increases, so does the use of prayer as a coping mechanism.⁵⁰

Assessing Mental Health Service Utilization and Needs of African Americans

Utilization rates are an important indicator of current and past service use patterns, but they cannot be considered an accurate index of mental health need. In fact actual mental health service needs may be grossly misunderstood if analyzed according to treatment rates. Thus, Atkinson, Morten and Sue report that in the post-Civil War North, high rates of mental illness among freed slaves were interpreted by some as an indication that freedom was too stressful for blacks; yet earlier in this century, low treatment rates for ethnic minorities were sometimes interpreted to mean that minorities had fewer or less severe mental health problems. Low use rates were used to justify policies that ignored the mental health concerns of minorities.⁵¹ Treatment utilization rates may reflect accessibility of services, help-seeking behaviors or diagnostic biases as well as, or instead of, mental health needs. African Americans, for example, have been over represented in inpatient settings since the early part of this century.⁵²

Recent research on mental health service utilization by African Americans has been inconclusive, with some studies reporting underutilization⁵³ ⁵⁴ and others suggesting

⁴⁹Broman, C.L. (1996). "Coping with Personal Problems." In H.W. Neighbors and J.S. Jackson (Eds.) *Mental Health in Black America*. Thousand Oaks, CA: Sage Publications.

⁵⁰Neighbors, H.W., Jackson, J.S., Bowman, P., and Gurin, G. (1983). "Stress, Coping, and Black Mental Health: Preliminary Findings From a National Study," *Prevention in Human Services*, 2(3): 5-29.

⁵¹Atkinson et al., op. cit.

⁵² Snowden, L.R., and Cheung, F.H. (1990). As cited in Atkinson et al. (Eds.), op. cit., p. 52.

⁵³Sue, S. (1977). "Community Mental Health Service to Minority Groups: Some Optimism, Some Pessimism," *American Psychologist* 32(8): 616-624.

⁵⁴Smith, E.J. (1981). "Mental Health and Delivery Systems for Black Women," *Journal of Black Studies* 12(2): 126-141.

overutilization, particularly of inpatient and residential care.^{55 56 57} A major problem with this research is that data are often based solely on the experiences of public health facilities, which African Americans may be more likely to access because of their lower socioeconomic status. It has been noted that African Americans and members of other minority groups may not pursue formal mental health intervention until a condition has become severe or chronic,⁵⁸ thus requiring more intensive intervention. African Americans are also more likely to be hospitalized involuntarily and to be diagnosed with more serious mental illness than are White Americans. Below are several related research findings:

- ◆ The admission rate to state psychiatric hospitals for African Americans was more than two times that of any other racial/ethnic group, according to a review of data.⁵⁹
- ◆ The admission rate to state psychiatric hospitals for African Americans ages 18 to 24 was 598 per 100,000, while the national mean was 163.6 per 100,000. For African Americans ages 25 to 44, admission rates were 753 per 100,000.⁶⁰
- ◆ The rate of admission of African Americans to private psychiatric hospitals was below that of whites.⁶¹
- ◆ Non-whites are 3.5 times more likely than whites to experience involuntary criminal commitment to psychiatric hospitals and 2.4 times more likely to experience involuntary noncriminal commitment.⁶²

⁵⁵ Flaskerud, J.H. and Hu, L. (1992). "Racial/Ethnic Identity and Amount and Type of Psychiatric Treatment," *American Journal of Psychiatry* 149(3): 379-384.

⁵⁶ Bui, K.T., and Takeuchi, D.T. (1992). "Ethnic Minority Adolescents and Use of Community Mental Health Care Services," *American Journal of Community Psychology* 20(4): 403-417.

⁵⁷ Dawkins, M., Dawkins, M.P., and Terry, J.A. (1979). "Personality and Lifestyle Characteristics of Users and Nonusers of Mental Health Services in an Urban Black Community," *Western Journal of Black Studies* 8: 43-52.

⁵⁸ Davis, K. (1997). *Exploring the Intersection Between Cultural Competency and Managed Behavioral Health Care Policy*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning (NTAC).

⁵⁹ Atkinson et al., op. cit.

⁶⁰ Manderscheid, R. (1987). As cited in Davis, op. cit.

⁶¹ Davis, op. cit.

⁶² Rosenstein, Milazzo-Sayre, MacAskill and Manderscheid. (1987). As cited in Atkinson et al., op. cit.

- ♦ African American patients are commonly diagnosed with more serious psychiatric illnesses than White Americans.^{63 64 65 66}
- ♦ African American patients are more likely to be diagnosed with schizophrenia whereas White American patients with the same behaviors are more likely to be diagnosed with depression.^{67 68}

Some authors, such as Lefley, suggest that higher inpatient admission rates may reflect "greater exposure to environmental stressors such as poverty, unemployment, neighborhood crime and substance abuse, loss of housing, and erosion of traditional support systems."⁶⁹ Others believe that the primary cause of the disproportionate rate of serious mental illness diagnoses among African Americans and other minorities is errors made by diagnosticians unfamiliar with behavioral norms or manifestations of mental illness among populations of color. Davis notes that "if their conclusions are valid, the cost savings to public and private mental health systems from implementing cultural competency skills in their clinical evaluations could be significant."⁷⁰

Substance abuse, of both illicit drugs and alcohol, also affects the mental health needs of African Americans. A 1995 study by the National Institute on Drug Abuse found that the prevalence of past-month illicit drug use by African Americans was slightly higher (6.8%) than for Hispanics (6.3%) or whites (5.5%). Rates of heavy alcohol use were roughly the same for all these

⁶³ Adebimpe, V.R. (1981). "Overview: White Norms and Psychiatric Diagnosis of Black Patients," *American Journal of Psychiatry* 138:279-285.

⁶⁴ Bell, C., and Mehta, H. (1979). "The Misdiagnosis of Black Patients with Manic Depressive-Illness," *Journal of the National Medical Association* 72: 141-145.

⁶⁵ Jones, B.E., Gray, B.A., and Parson, E.B. (1981). "Manic-Depressive Illness among Poor Urban Blacks," *American Journal of Psychiatry* 185: 654-657.

⁶⁶ Strakowski, S.M., Lonczak, H.S., Sax, K.W., West, S.A., Crist, A., Mehta, R., and Thienhaus, O.J. (1995). "The Effects of Race on Diagnosis and Disposition from a Psychiatric Emergency Service," *Journal of Clinical Psychiatry* 56(3): 101-107.

⁶⁷ Raskin, A., Crook, T.H., and Herman, K.D. (1975). "Psychiatric History and Symptom Differences in Black and White Depressed Inpatients," *Journal of Consulting and Clinical Psychology* 43: 73-80.

⁶⁸ Spitzer, R.L., Endicott, J. and Robbins, E. (1978). "Research Diagnostic Criteria. Rationale and Reliability," *Archives of General Psychiatry* 35: 773-782.

⁶⁹ Lefley, H.P. (1994), as cited in Atkinson et al., op. cit., p. 57.

⁷⁰ Davis, K. (1997), op. cit., p. 8.

racial/ethnic groups.⁷¹ A 1994 study at an inner-city hospital, where 57 percent of study participants were African American, found that 34.7 percent of patients had current mental health problems related to substance abuse, with no prior diagnosis of an independent mental disorder. Mental health diagnoses among this group included major depression (15.4%) and brief psychotic disorders (8%). Another 25.1 percent had an unrelated pre-existing mental illness along with a substance abuse problem; pre-existing conditions included major depression, schizophrenia and bipolar disorders. No differences were reported between African Americans and White Americans in this study.⁷²

Several studies estimate the rate of co-morbidity of mental illness and substance abuse at about 50 percent for patients admitted to public psychiatric hospitals.^{73 74 75} While studies have established high rates of dual diagnosis among the general population and psychiatric inpatients, little is known about the interplay of substance abuse and mental illness among African Americans. Existing comparative studies cannot reflect the heterogeneity of mental health problems and help-seeking behavior within the black population due to the small number of African Americans sampled in most population surveys.⁷⁶

One study with a large sample-base suggests that there may be a link between trauma and stress and the use of alcohol among African Americans. Using a national probability sample of 1,478 African Americans, researchers found that those who reported stressful losses or whose extended family members experienced such losses were significantly more likely to drink excessively.⁷⁷ Additionally, a 1996 study found a highly significant relationship between problem drinking and

⁷¹ U.S. Dept of Health and Human Services. (1995). *Substance Abuse and Mental Health Statistics Sourcebook*. Washington, D.C.: U.S. Government Printing Office.

⁷² Lehman, A.F., Myers, C.P., Corty, E. and Thompson, J.W. (1994). "Prevalence and Patterns of 'Dual Diagnosis' Among Psychiatric Inpatients," *Comprehensive Psychiatry*, 35(2), 106-112.

⁷³ Alterman, A.I., Erdlen, F.R., McLellan, A.T., and Mann, S.C. (1980). "Problem Drinking in Hospitalized Schizophrenic Patients," *Addicted Behaviors* 5: 273-276.

⁷⁴ Galanter, M., and Castaneda, R. (1991). "Studies of Prevalence of Dual Diagnosis in Psychiatric Practice." In M.S. Gold and A.E. Slaby (Eds.) *Dual Diagnosis in Substance Abuse*. New York: Dekker.

⁷⁵ Crowe, D.B., Rosse, R.B., Sheridan, M.D., and Deutsch, S.I. (1991). "Substance Use Diagnoses and Discharge Patterns among Psychiatric Inpatients," *Hospital and Community Psychiatry* 42: 403-405.

⁷⁶ Veroff et al., op. cit.

⁷⁷ Johnson, K.A., and Jennison, K.M. (1994). "Stressful Loss and the Buffering Effect of Social Support on Drinking Behavior among African-Americans: Results of a National Survey," *Journal of Alcohol and Drug Education* 39(2): 1-24.

"nervous conditions" in a sample of 2,107 African Americans.⁷⁸ More thorough research may permit firmer conclusions to be drawn about African American co-morbidity rates and comparisons with other ethnic and racial groups.

Atkinson, Morten and Sue, discussing factors that contribute to the mental health needs of minorities, note that "to the extent that stress leads to mental health problems, it can be hypothesized that the unique or particularly intense sources of stress experienced by ethnic minorities will generate greater mental health problems among these groups than among European Americans."⁷⁹ Some authors have advocated that researchers and policymakers consider the stressors and coping resources unique to African Americans to better understand how race affects mental health status. Following this line of research, several investigators have concluded that African Americans experience more stressors than White Americans, largely due to the impact of oppression and membership in a visible, isolated and marginalized minority group, even when class is controlled.^{80 81}

Cultural Characteristics Affecting Use of Mental Health Services

Perceptions of Mental Illness

Mental health issues of African Americans tend to differ from those of White Americans due to African Americans' unique historical, political, sociological and cultural experiences. It is useful to explore how distinct cultural perspectives affect the identification of mental health needs and accessibility of and desire for services. However, highlighting cultural characteristics within the diverse African American population can also lead to oversimplifying and stereotyping the needs of African American consumers and families.

This discussion of cultural and ethnic characteristics is intended to offer guidance to mental health service providers and advocates who work with African Americans, but this information should not be generalized to necessarily apply to all African American consumers. African

⁷⁸ Obot, I.S. (1996). "Problem Drinking, Chronic Disease and Recent Life Events." In H.W. Neighbors and J.S. Jackson (Eds.) *Mental Health in Black America*. Thousand Oaks, CA: Sage Publications.

⁷⁹ Atkinson et al., op cit., p. 57.

⁸⁰ Ulbrich, P.M., Warheit, G.J., and Zimmerman, R.S. (1989). "Race, Socioeconomic Status, and Psychological Distress: An Examination of Differential Vulnerability," *Journal of Health and Social Behavior*, 30(1), 131-146.

⁸¹ Dohrenwend, B.S. and Dohrenwend, B.P. (Eds.). (1981). *Stressful Life Events and Their Contexts*. New York: Prodist.

Americans are a heterogeneous group whose help-seeking behavior depends to a large extent on age, education, gender, marital status, employment and other significant personal, socioeconomic and demographic factors.⁸²

Traditional beliefs and cultural perceptions have a significant impact on some African Americans' understanding of and coping with mental illness. For many African Americans, mental illness carries a heavy stigma and is viewed as "going off" or "not being right in the head." Mental illness may also be seen as a consequence of not "living right" or "not being right with God."

Also, until recent decades some African Americans traditionally believed that mental illness involved the power of the hex and that the "working of roots" (the use of plant roots to prepare potions) could cause or solve both psychological and somatic problems. Root doctors are still consulted as healers by some older Black Americans living in the rural South.^{83 84} Some newer immigrants from Africa and the West Indies hold similar beliefs. For people who rely on local healers, or see mental illness as a spiritual problem or a source of stigma, the mental health system might not be consulted except as a last resort after other interventions have failed.

The stigma associated with mental illness may be exacerbated by race- and class-related stigma and discrimination. Boyd-Franklin notes that "many Black families perceive therapy to be the process of labeling them as crazy, often fearing the reaction of their extended family members, friends, and community. This is compounded by the fact that Black families are often not self referred, but are sent for treatment by schools, courts, hospitals, or social welfare agencies, often under considerable threat or pressure."⁸⁵

Griffith and Baker point out that until the 1940's, African Americans with psychiatric disorders were often hidden away or sent to be with family members who lived in the South or on farms.⁸⁶ These authors note that with the advent of community mental health centers and increased public

⁸² Mays, V.M., Caldwell, C.H., and Jackson, J. (1996). "Mental Health Symptoms and Service Utilization Patterns of Help-Seeking Among African American Women." In Neighbors, H.W., and Jackson, J.S. (Eds.) *Mental Health in Black America*. Thousand Oaks, CA: Sage Publications.

⁸³ Jordan, W.C. (1975). "Voodoo Medicine." In Williams, R.A. (Ed.) *Textbook of Black-Related Diseases*. New York: McGraw-Hill. pp. 715-738.

⁸⁴ Ness, R.C., and Wintrob, R.M. (1981). "Folk Healing: A Description and Synthesis." *American Journal of Psychiatry*. 138: 1477-1481.

⁸⁵ Boyd-Franklin, op. cit.

⁸⁶ Griffith, E.E., and Baker, F.M. (1993). "Psychiatric Care of African Americans." In Gaw, A.C. (Ed.) *Culture, Ethnicity, and Mental Illness*. Washington, DC: American Psychiatric Press.

awareness of psychiatric illness, acceptance and knowledge of mental disorders in the African American community have improved but that mental illness is still often experienced as stigmatizing and embarrassing. Many problems are likely to be ignored or denied until they become severe enough that intervention is absolutely necessary, often due to pressures from the external systems noted above.

Perceptions of Mental Health Care

Many factors have been cited that may affect the use of mental health services by African Americans, including:

- ◆ Some African Americans may be more comfortable utilizing community social supports rather than the public mental health system because relying on community supports may trigger fewer feelings of guilt, humiliation or powerlessness.⁸⁷
- ◆ For some African Americans, turning to a mental health professional rather than solving their problems through prayer signifies a lack of faith and trust in God.
- ◆ Many African Americans may be unaware of services that mental health providers offer and, thus, may not utilize available community-based counseling resources.⁸⁸
- ◆ In some cases, African Americans have had negative experiences with counselors in public schools and may hesitate later to seek the help of counselors in the community.
- ◆ In some African American communities, mental health work may be a devalued and distrusted occupation, which can affect whether community members seek help or delay treatment. A minister may be perceived as more competent to provide mental health care than a provider of the same race.
- ◆ Hines and Boyd-Franklin suggest that "African Americans may also fear misdiagnosis, prescription of medications for behavioral and population control, and governmental abuse of clinical files. These concerns arise out of incidents such as the 'Tuskegee

⁸⁷ Hines, P.M., and Boyd-Franklin, N. (1996). "African American Families." In M. McGoldrick, J. Giordano and J.K. Pearce (Eds.) *Ethnicity and Family Therapy*. New York: Guilford Press.

⁸⁸ McDavis, R.J., Parker, W.M., and Parker, W.J. (1995). "Counseling African Americans." In Vacc, N.A., De Vaney, S.B., and Wittmer J. (Eds.) *Experiencing and Counseling Multicultural and Diverse Populations*. Bristol, PA: Taylor & Francis.

Study,' where for four decades, Black men with syphilis were monitored, but not treated, in a program that involved the complicity of doctors and governmental officials."⁸⁹

- ◆ Seeking help from a mental health professional may be viewed as turning to representatives of a system that has negatively influenced African American well-being.
- ◆ Some African Americans who are Islamic and/or Black Nationalist may be hesitant to accept services from non-African American providers.

Instead of mental health services, many African Americans turn to other supports to meet their mental health needs. Data from a National Survey of Black Americans indicates that a majority of African Americans make extensive use of informal helper networks when faced with severe personal problems.⁹⁰ These networks, as noted above may include family and other relatives, friends, pastors and church members.⁹¹ ⁹² Recognizing and utilizing these assets within the community may provide a venue for overcoming barriers to culturally sensitive service delivery.

SMHA Strategies To Overcome Barriers

There are several ways that state mental health agencies (SMHAs) can begin to address and minimize cultural barriers to utilization. Effective strategies include:

- ◆ building relationships between mental health providers and religious leaders, traditional healers and other informal sources of social support in the African American community to increase public awareness and understanding of the available mental health services and to increase cooperation and cross-referral.⁹³

⁸⁹ Hines and Boyd-Franklin, op. cit.

⁹⁰ Jackson, J.S., Chatters, L.M. and Neighbors, H.W. (1986). "The Subjective Life Quality of Black Americans." In Andrews, F.M. (Ed.), *Research on the Quality of Life*. Ann Arbor: University of Michigan Press. (Pp. 193-203.)

⁹¹ Taylor, R.J. (1986). "Receipt of Support From Family Among Black Americans: Demographic and Familial Differences," *Journal of Marriage and the Family* 48(1) 67-77.

⁹² Taylor, R.J. and Chatters, L.M. (1988). "Church Members as a Source of Informal Social Support," *Review of Religious Research* 30(2) 193-203.

⁹³ Cheung, F.K. (1991). "The Use of Mental Health Services by Ethnic Minorities." In H.F. Myers, P. Wohlford, L.P. Guzman and R.J. Echemendia (Eds.). *Ethnic Minority Perspectives on Clinical Training and Services in Psychology*. Washington, D.C.: American Psychological Association. (pp. 23-31).

-
- ◆ establishing community mental health centers in the African American community and encouraging consumers to perceive these services as a part of their community and to make better use of them;⁹⁴
 - ◆ employing staff who reflect the community's cultural and ethnic mix. Consumers may be more willing to accept professionals from their own culture, as well as paraprofessionals and peers who have resolved similar mental health issues;⁹⁵
 - ◆ providing services such as a series of community-based educational presentations with particular emphasis on community social problems such as domestic violence or drug abuse. In these settings participants can receive information and assistance without the need for self-disclosure or for clinicians to make a diagnosis. Individuals can remain anonymous until they trust the organization enough to seek further help;
 - ◆ employing therapists who recognize that mental health concerns exist in a broader social context that may include the courts, employment, financial issues, the welfare system, schools and housing. With these real-world, day-to-day concerns, individual mental health needs often may be at the bottom of consumers' priority lists. Counselors should be prepared to adopt a more holistic, systems-oriented approach in working with African American consumers with these types of external pressures; and
 - ◆ transporting clients from various treatment facilities to a centralized setting where needs can be met in culturally specific group therapy, particularly in locales where there are only a small number of African American consumers and staff.

Broad political, historical and sociological influences combine with traditionally organized service systems to create significant barriers to meeting the mental health needs of African Americans who may be unfamiliar with or distrustful of public systems. The two programs profiled below recognize these dynamics and actively seek out and use the strengths and resources of African American staff and consumers and of the greater African American community.

African American Family Services in Minnesota and The Village Project of Charleston/Dorchester Community Mental Health Center in South Carolina have successfully implemented strategies to make their programs culturally competent and attractive to African American consumers. The success of these programs is due, in part, to their holistic approach, which includes creating an accepting environment for services and offering a wide range of supports and services—including mental health services—to interested individuals.

⁹⁴ McDavis et al., op. cit.

⁹⁵ Cheung, op. cit.

Model Program: African American Family Services

African American Family Services operates within a framework of "cultural specificity," defined as the creation of an environment in which the identity and experience of a people in a specific group or culture are recognized, explored and accepted.

Overview

African American Family Services (AAFS) is a private, nonprofit agency founded in 1975, providing mental health and substance abuse treatment services for African Americans. With a current annual operating budget of \$3 million and 80 full and part-time employees, the agency operates three facilities in Minneapolis-St. Paul, Minnesota. AAFS' mission is to empower African American individuals, families and communities to reach a greater state of well-being through the delivery of community-based, culturally-specific chemical health, mental health and family preservation services. Although its programs are culturally-specific for African Americans, AAFS provides services to those from other groups who desire services. Many people who are biracial, who are in interracial relationships or multi-cultural families, or who consider themselves part of the African American community receive services through the agency.

Cultural Perspective

African American Family Services operates within a framework of "cultural specificity," defined as the creation of an environment in which the identity and experience of a people in a specific group or culture are recognized, explored and accepted. For many African Americans, establishing a positive self-image and sense of self-esteem can be extremely difficult as a result of years of painful experiences as members of an oppressed and devalued group. Centuries of external oppression of African Americans has led to internalized oppression. Thus, not only do some White Americans believe in white superiority, but some African Americans also share this belief.

As a member of an easily identifiable, oppressed ethnic group, African Americans are often judged collectively—rather than as individuals—by the broader society. When an African American is accused of wrongdoing, all African Americans may be viewed as responsible. Such collective judgments can lead to the collective experience of shame. AAFS seeks to create a safe, supportive environment where such issues as external and internal oppression, collective judgment and shame, cross cultural ignorance and racism can be addressed, understood and

resolved. Establishing a positive identity is an important part of the process of achieving sobriety, mental wellness, self-sufficiency and an improved quality of life.

AAFS helps people understand that although prejudice, discrimination and other societal issues can be painful, they are not the cause of chemical dependency, violence, welfare dependency and hopelessness. AAFS strives to empower its consumers by acknowledging their pain, rage and shame and by acquainting them with positive role models who have faced and overcome the same obstacles. By focusing on consumers' strengths and resources and helping them develop new ones, AAFS encourages consumers to become stakeholders in their own future and to build a sense of hope, courage and increased self-esteem, all prerequisites to becoming self-sufficient, contributing members of society.

Services and Supports

The following is a comprehensive overview of AAFS' four divisions.

- ◆ **The African American Counseling Center** oversees mental health services, adult violence services, adolescent violence services and family preservation programs. Mental health counseling services are available to individuals and families to reduce individual and family crises, increase family stability of AAFS clients in other agency programs, and respond to the mental health needs of the African American community. Groups focusing on grief and loss for adults and children, and violence and anger management programs, evolved in response to the ravages of violence and the effects of family disruption experienced in the community.

The Counseling Center's Adult Violence Services includes the Sisters Advocating for Empowerment Program (SAFE) and the Male Oppression and Violence Elimination Program (MOVE). SAFE offers advocacy, referral and support for female survivors of domestic violence and community education for other service providers and women. MOVE offers treatment and re-education for male perpetrators. Referrals to this program come from the courts, corrections, child protective services and self-referral. Men must be willing to take responsibility for their behavior and acknowledge a sincere desire to work toward change.

In addition, Violence Treatment and Prevention Programs for adolescent males and females treat youth who have acted violently either at home, in school or in the community and reintegrate juveniles discharged from residential programs into the community.

Finally, Family Preservation and Housing Assistance programs combine family preservation theories and approaches with AAFS' own culturally-specific approaches and knowledge. Programs are offered to families in the home or

shelter and/or through counseling on site. Referrals come from all AAFS programs, child protective services, corrections, community agencies, low income housing managers, schools and self-referrals.

- ◆ **The Institute on Black Chemical Abuse** addresses the multi-faceted issues of chemical health in a culturally-specific manner. Services available for youth and adults include assessment and intervention; outpatient treatment and relapse prevention; transition and aftercare case management and support groups; and chemical free recreation, retreats and volunteer opportunities. An informational "Chalk Talk" lecture series provides information about drugs, alcohol and chemical dependency for family, friends, community members and at-risk users who do not qualify for treatment. Also a co-dependency lecture series for family and friends as well as the chemically dependent is offered.
- ◆ The African American Resource Center offers a combination of services designed to reach the entire community. Books, pamphlets, audiotapes, videos and pre-assembled packets are available dealing with a multitude of issues that pertain to families: gender differences, parenting and youth, race and culture, substance abuse and treatment, violence, etc. The Resource Center's prevention component includes a youth prevention program matching youth and elders, cross-peer mentoring, social competency educational lectures, awareness groups, and other community prevention projects. These activities serve as a catalyst for the establishment of healthy cultural norms regarding chemical use/abuse, violence and crime in the African American community.
- ◆ **The Technical Assistance Center (TAC)** creates training programs for counselors, agency administrators and boards of directors, and other service professionals throughout the United States. Participants receive tools and techniques to enhance and improve their service delivery to African American consumers.

Funding

This array of services is funded through contracts with several counties, the state Department of Human Services, the local United Way and the state Department of Corrections. The agency also has contracts with several major health insurance carriers and managed health care providers for licensed outpatient chemical dependency treatment services, psychological testing and mental health counseling.

The majority of mental health services are funded by United Way contracts and a contract with Hennepin County. Although the agency has not received major state mental health funding, it serves as the fiscal agent for the Hennepin County children's mental health initiative. Given these alternate (non-insurance) funding streams, AAFS has the flexibility to provide

individualized treatment (the duration of treatment is not diagnosis driven) and to utilize a range of well-trained counselors who may not yet be licensed. The agency hires counselor aides, often former clients, who serve as excellent peer role models. AAFS also operates a peer adolescent prevention program that hires and trains adolescents to provide peer prevention services.

Coordination and Accessibility

African American Family Services strives to provide coordinated and accessible services. In addition to internal coordination, AAFS collaborates with agencies throughout the Minneapolis-St. Paul region. In 1996 the agency received client referrals from 140 agencies and provided services to 29 schools. AAFS' assessment services are a portal of entry for many persons seeking chemical dependency treatment, and its transition and aftercare services provide ongoing support for clients leaving other treatment programs. AAFS' programs collaborate closely with local women's domestic violence shelters and homeless shelters.

To ensure that AAFS is accessible to its clientele, the agency provides drop-in child care and transportation for many clients, which removes major barriers to receiving services. The agency also offers educational programs open to the community on such topics as chemical dependency, domestic violence, mental health, cultural pain and relationships. Since the lectures do not require participants to self-disclose or become clients, these programs are non-threatening. People who are not yet ready to commit to a therapeutic relationship can still receive information and help. After attending public lectures, participants often call and ask for an individual appointment.

Evaluation

AAFS agency-wide evaluation reveals promising statistics:

- ◆ The chemical dependency outpatient treatment program's completion rate is 40 percent, a significant level given that AAFS serves a number of clients who enter treatment at a later stage in debilitation. An even more impressive sign of success, however, is the number of clients actively involved in transition and aftercare support groups, case management, sober recreation and volunteerism. In 1996, 407 clients were actively involved in aftercare support, 95 people attended sober retreats and 1,200 attended transition lectures. African American Family Services received 12,000 hours of volunteer services in 1996. The majority of this time was donated by people in recovery who realize that in order to maintain their sobriety they must help others.
- ◆ Each year approximately 50 percent of mental health clients achieve outcomes of increased ability to problem solve or identify resources for support.

-
- ◆ In 1997 approximately 66 percent of male participants graduated from the MOVE program and have not re-offended.
 - ◆ From May 1996 through May 1997, 56 adolescent males participated in the violence treatment program. At 3-, 6-, and 9-month follow ups, none of the graduates had re-offended or violated probation.

Contact Information

For further information, contact:

Salimah Majeed, L.I.C.S.W.
Executive Director
African American Family Services
2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878

Model Program: The Village

Guided by the belief that cultural competence should include both an overarching philosophy and a corresponding set of strategies, The Village has translated cultural competence into a service system design that taps into the strengths of its clientele and the community and provides meaningful community-based choices.

Overview

The Village provides a system of care for children and their families that blends child-centered, wrap-around services based on the Child and Adolescent Service System Principles (CASSP) with the conviction expressed by Gary Melton⁹⁶ that help must be delivered when families need it, where they are, and in a form they find useful and non-stigmatizing. The program, which is overseen by the Charleston/Dorchester South Carolina Community Mental Health Center (CMHC), provides services for young people through age 17 with serious emotional and behavioral difficulties and their families. Family involvement at all levels of services and policy development is a key component of the program.

Operating within the South Carolina Department of Mental Health's Division of Services for Children, Adolescents and Their Families (CAF), with additional funding provided by the federal Center for Mental Health Services (CMHS), The Village initiative has greatly expanded the range of services available to children and their families beyond traditional in-office clinical services. Since its inception in 1993, The Village has provided intensive, home-based teams to work with children who are at risk of family disruption and/or acting out. The program also has become a strong presence in local schools and the community.

The geographical and demographic makeup of The Village's catchment area includes both urban and rural areas as well as wealthy and poor neighborhoods. The areas of poverty tend to run along racial lines, with African Americans and other ethnic or racial minority families living in poorer sections. Prior to the establishment of The Village, the Charleston/Dorchester CMHC provided services to families who lived in urban areas of the community. Families in rural areas, especially the coastal islands, were often unable to gain access to services. In 1992, 85 percent of families who participated in mental health services were from urban areas; only 15 percent were from rural areas. By 1994, after The Village came into being, 43 percent of families participating in services were from rural areas, and 57 percent were from urban areas. Greater

⁹⁶Melton, G. (1997). "Going Where the Kids Are." In Melton, Garbarino and Wilcox (Eds.) *Family Futures*, Volume I (1), NJ: Lawrence Erlbaum Associates.

access for rural families was a direct result of moving mental health services into rural community settings that were familiar and accessible.

The racial and ethnic breakdown of the population in the catchment area is about 60 percent white; 30 percent African American; and 10 percent Asian, Latino and Native American. Recent data on race and ethnicity of families served by the program reflect the success of The Village's efforts to reach out to previously underserved consumers:

- ◆ African American: 69.7 %
- ◆ White: 30 %
- ◆ Hispanic: 0.3 %

These CMHC service statistics mirror the rates of services within the child welfare and criminal justice systems, two of the systems with which the Center has aligned itself.

The Village has adopted a multi-system approach that better reflects the reality of children and their families who are linked to multiple systems. Consequently, many mental health services and supports are available through homes, schools, child welfare offices, juvenile detention centers, mental health clinics, substance abuse service clinics, private not-for-profit centers for the assessment and treatment of child abuse and services for families who are homeless. The CMHC jointly plans and coordinates efforts with other child-serving agencies with which it also shares resources such as funding, staff, office space and training.

In addition to African American children and families, The Village is making inroads with other ethnic, racial and rural populations. Access to mental health programs has been increased for families living in isolated coastal communities by placing mental health staff at local schools and primary health care facilities and making teams available to families in their homes. Staff regularly participate in community activities.

One example of The Village's multicultural efforts is The Village Early Intervention Project (VEIP), which provides services in the island communities, where many Hispanic families live either temporarily while working in seasonal agriculture or permanently. The VEIP employs bilingual therapists and consultants to conduct therapy in Spanish and prints all program materials in Spanish.

The stigma of mental health services is a major barrier in this small community. Staff work diligently to interact with families and residents in places other than clinical settings. The clinic site on the island has no identifying sign to create potential stigma. VEIP hired several staff members who reside in the community and who serve as ambassadors and information providers for other residents. In this community, it is much more acceptable to acknowledge substance abuse than psychiatric problems. Thus, VEIP provides services to families who are not prepared

to acknowledge psychiatric problems at the outset. As the therapeutic alliance develops, mental health issues often are identified and become a focus of treatment.

Although the Charleston/Dorchester area's Latino and Native American populations are relatively small, The Village strives to offer child-centered services to these populations. Because there are fewer community resources tailored for the needs of these groups, The Village staff are often creative and draw upon a wide range of resources to assist consumers from diverse ethnic backgrounds. For example, staff rely on a state-generated list of interpreters for work with Native Americans.

Values

The Village's core concept, which has been influenced by the work of Howard Stevenson and Saburah Abdul-Kabir,⁹⁷ is to seek assistance from peer mentors in the community who are resilient and skilled in dealing with issues of isolation and social system conflict. This explicit partnership with community members is essential because it:

- ◆ recognizes the importance of cultural expression,
- ◆ acknowledges that parents may not trust "the system,"
- ◆ understands that every neighborhood has unique strengths, and
- ◆ realizes that a kinship network exists and identifies it as the first point of contact:

The program's emphasis on therapeutic kinship care recognizes that families may wish to and be able to care for youth with serious emotional and behavioral difficulties as an alternative to out-of-home residential treatment. It must be recognized, however, that families should have the same level of support and services that are available to professional providers who care for children with serious emotional problems. This may mean designing services that include wrap-around, respite and in-home services, as well as after-school programs and other necessary services. Families should be able to define what "kin" means and should be supported in participating in services to the extent that they are comfortable and able.

By blending the child-centered, wrap-around services characterized by the Child and Adolescent Service System Program Principles⁹⁸ with the belief that help must be delivered when families need it, where families are, and in a form families can use with ease and without stigma, The

⁹⁷Stevenson, H., and Abdul-Kabir, S. (1995). *Reflections of Hope from the Bottom: Cultural Strengths and Coping Among Low-Income African American Mothers*. Paper presented at the Roundtable on Cross Cultural Psychotherapy, Teachers College, Columbia University, New York, NY.

⁹⁸ Stroul, B.A., and Friedman, R.M. (1986). *A System of Care for Severely Emotionally Disturbed Children and Youth*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Village has created a culturally competent system that can be utilized with children and families of any culture. The Village has identified the following activities as essential to the creation of a culturally competent program or system that is welcoming to all:

- ◆ Assess and acknowledge the impact of the practitioners' own culture on the mental health intervention.
- ◆ Assess and acknowledge the impact of the consumer's and the family's culture.
- ◆ Teach staff to assess specific cultural indicators.
- ◆ Acknowledge the impact of oppression on a family's mental health.
- ◆ Understand how certain behaviors that may seem unusual to others "fit" within the context of a family's values and cultural norms.
- ◆ Avoid misinterpreting family behaviors as pathological when the behaviors may be normative within the family's culture.
- ◆ Institutionalize the commitment to culturally competent knowledge and progress through activities such as establishing a cultural competence committee, requiring staff involvement in cultural competence training programs, providing monthly readings about cultural issues, displaying newspapers that focus on news about people of color and hosting staff meetings with cultural themes.
- ◆ Conduct ongoing self-assessments of all aspects of the mental health system.

Services and Supports

The Village offers an array of services that have been developed during the past five years. In addition to more traditional services such as out-of-home placements and inpatient and long-term residential care, The Village has added a variety of flexible and responsive wrap-around services that support the child and family and maximize their success. These include:

- ◆ *Formalized parent support and advocacy.* The Village employs several full-time and part-time family representatives to develop family support networks and advocacy activities.
- ◆ *Village Early Intervention Project.* An intensive treatment program for families with children through age 7 in which the adult care giver has substance abuse problems and/or a psychiatric disability. Clinical staff from the community mental health center and Department of Alcohol and Other Drug Abuse Services

work in teams with families utilizing targeted interventions for both adults and children.

- ◆ *Sexual aggression treatment programs.* Specialized services for victims of child sexual assault and youth who are sexually aggressive. Children who are identified as low or moderate risks for committing further acts of sexual aggression receive treatment in their homes and communities as opposed to being sent to restrictive residential facilities.
- ◆ *Designated emergency fund.* These flexible funds are used to purchase services and goods for children and families in order to stabilize them at home. Funds might be spent on shoes, medication and/or therapeutic respite camp.
- ◆ *Youth violence prevention initiative.* Programs include developing youth forums and speak-outs, establishing bully-free schools and working directly with youth already involved in the juvenile justice system.
- ◆ *Babynet.* A mental health counselor provides therapeutic services to families with children age birth through 3 who are experiencing significant disabilities and delays. Primary focus is on family issues such as parent training, stress management and sibling relationships.
- ◆ *Job apprentice program.* This program for teenagers pays wages for three months. After participating in the apprenticeship, youth volunteer for a period of time with the hope that they will obtain staff positions.

Funding

Launched with federal funding, The Village receives substantial financial support from the South Carolina Department of Mental Health (DMH), which contributed the required state match for the federal grant and has increased the state funding as federal dollars have declined. In addition, funding sources such as the Department of Alcohol and Other Drug Abuse Services (DAODAS), Medicaid, private insurance and self-pay revenue have allowed The Village to continue its comprehensive array of services. Finally, The Village continues to expand services by obtaining additional grant funds. For example, in 1998 new funds were obtained for additional school-based services, early intervention, youth violence prevention and youth-in-transition to adulthood services.

Coordination and Accessibility

To foster linkages and coordination with other child-serving systems, The Village has adopted two primary strategies: coordination and co-location. For example, several mental health staff

are co-located at the local child welfare offices, allowing collaboration in designing the most appropriate clinical services and support. Another mental health counselor provides services at the Department of Social Services emergency shelter, where children who have experienced abuse and neglect are first placed when taken into custody.

Coordination across systems also is enhanced by weekly consultations with families, family advocates and representatives from multiple systems (juvenile justice, mental health, child welfare, alcohol, school district, disability) to review and discuss several families' needs, plans and services. Finally, The Village Coordinating Council, made up of family members and representatives of public and private service agencies, meets regularly to monitor implementation of federal and state grants, identify gaps in the service array and plan new activities.

The Village has implemented several changes to enhance access for its ethnically and racially diverse clientele. The Village consulted with the state-level director of cultural competence, staff, and consumer families in implementing a variety of changes, including displaying artwork more representative of the entire community and literature that appeals to all groups in the waiting room. In addition, state emblems were removed from cars used for home visits to avoid stigmatization.

The Village actively recruits professionals of color to create diversity among providers. The program has established a team of bachelor-level paraprofessionals, many of whom are African American, to work with children and their families. Although maintaining a diverse staff is important, the program contends that cultural competence is not achieved simply by matching staff with families based on ethnic or racial background. A more significant component of cultural competence is providing consumers with a variety of choices for community-based services.

Evaluation

In accordance with requirements of its CMHS funding, The Village was among 40 sites that participated in a national evaluation protocol that ended September 1998. Initial evaluation results reveal significant progress in meeting the needs of a diverse clientele, including:

- ◆ Waiting time for families seeking services has decreased from more than six weeks in 1993 to five days currently. (Families with emergencies continue to be seen on the same day.)
- ◆ The proportion of rural families participating in services has increased from 15 percent in 1992 to 43 percent in 1994 as a result of placing staff in rural schools and expanding home-based services.

-
- ◆ The rate of hospitalization of youth in the state psychiatric hospital (located two hours from The Village) decreased by 73 percent between 1993 and 1996.
 - ◆ Prior to enrollment in an intensive day school/mental health program, 86 percent of youth had at least one out-of-home placement. Since participation in the program, out-of-home placements have decreased by 77 percent.
 - ◆ Overall, child functioning improved significantly from intake to 6 months to 1 year as measured by the Child and Adolescent Functional Assessment Scale (CAFAS).
 - ◆ Of the 166 families that answered family satisfaction questions after 6 months in the program, 82 percent indicated that services for their children were "excellent" (51 percent) or "good" (31 percent).

Guided by the belief that cultural competence should include both an overarching philosophy and a corresponding set of strategies, The Village has translated cultural competence into a service system design that taps into the strengths of its clientele and the community and provides meaningful community-based choices. Through this initiative, The Village has been able to attract more of the African American residents in the communities it serves.

Contact Information

For further information, contact:

Mr. Mac Magee, M.Ed.
The Village Project
Charleston/Dorchester Community Mental Health Center
3346 Rivers Avenue, Suite D-1
North Charleston, SC 29405
(843) 740-6136

Suggested Readings

American Counseling Association. (1999). *Journal of Counseling and Development* 77(1).

American Counseling Association. (1998). *Journal of Counseling and Development* 76(4), 76(3) and 76(2).

American Counseling Association. *Journal of Multicultural Counseling and Development* (Various issues).

American Psychological Association (APA). (1990). *Guidelines for Providers of Psychological Services to Ethnic, Linguistic and Culturally Diverse Populations*. Washington, DC: American Psychological Association.

Arredondo, P. (1996). *Successful Diversity Management Initiatives: A Blueprint for Planning and Implementation*. Thousand Oaks, CA: Sage Publications.

Arredondo, P., Toporek, R., and Brown, S., et al. (1996). *Operationalization of Multicultural Counseling Competencies*. Alexandria, VA: Association of Multicultural Counseling and Development.

Atkinson, D. and Hackett, G. (1997). *Counseling Diverse Populations*. New York, NY: McGraw Hill College Division.

Atkinson, D., Morten, G., and Sue, D. (1998). *Counseling American Minorities: A Cross-Cultural Perspective, 5th Edition*. New York, NY: McGraw-Hill.

Davis, K. *Consumer-Driven Standards and Guidelines in Managed Mental Health for Populations of African Descent*. Virginia Commonwealth University.

Davis, K. (1997). *Exploring the Intersection Between Cultural Competency and Managed Behavioral Health Care: Implications for State and County Mental Health Agencies*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Gaw, A. (Ed.). (1993). *Culture, Ethnicity and Mental Illness*. Washington, DC: American Psychiatric Press.

Gay, Lesbian, Bisexual and Transgender Health Access Project. (1999). *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients*. Boston, MA: Massachusetts Department of Mental Health.

Gay, Lesbian, Bisexual and Transgender Health Access Project. (1997). *Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community, 2nd Edition*. Boston, MA: Massachusetts Department of Mental Health.

Lynch, E. and Hanson, M. (1998). *Developing Cross-Cultural Competence: A Guide for Working with Children and Their Families*. Baltimore, MD: Paul H. Brookes Publishing Co.

Miller, C., Peck, L., Shuman, J., Ym-Calenti, C. (1995). *Building Bridges: Tools for Developing an Organization's Cultural Competence*. Tucson, AZ: La Frontera.

Munoz, R., and Sanchez, M. (1997). *Developing Culturally Competent Systems of Care for State Mental Health Services*. Boulder, CO: Western Interstate Commission for Higher Education.

National Resource Center on Homelessness and Mental Illness. (November 1996). *Annotated Bibliography, Cultural Competence in Treatment and Services*. Delmar, NY: Policy Research Associates.

Office of Refugee Resettlement. (1991). *Promoting Mental Health Services for Refugees: A Handbook on Model Practices*. Washington, DC: U.S. Department of Health and Human Services, Family Support Administration.

Ohio Department of Mental Health, Minority Concerns Committee and Diversity Action Team. (1994). *Accomplishments Toward the Development of a Culturally Competent Mental Health System (1988-1994)*. Columbus, OH: Ohio Department of Mental Health.

Ponterotto, J. (1995). *Handbook of Multicultural Counseling*. Thousand Oaks, CA: Sage Publications.

Ponterotto, J., and Pedersen, P. (1993). *Preventing Prejudice: A Guide for Counselors and Educators (Multi-Cultural Aspects of Counseling, Vol. 2)*. Thousand Oaks, CA: Sage Publications.

Portland State University Research and Training Center on Family Support and Children's Mental Health. (1990). *Issues in Culturally Competent Service Delivery: An Annotated Bibliography*. Portland, OR: Portland State University.

Sue, D., and Sue, D. (1999). *Counseling the Culturally Different: Theory and Practice*. New York, NY: John Wiley and Sons.

Sue, D., Ivey, A., Pederson, P., et al. (1996). *A Theory of Multicultural Counseling and Therapy*. Baltimore, MD: Brooks/Cole Publishing Co.

Sue, S. (1983). *The Mental Health of Asian Americans*. San Francisco, CA: Jossey-Bass Publishers.

Trout, B.A. (1999). "The Never-Ending Journey Towards Cultural Competence in the Charleston Village: If It Doesn't Feel Like Help, It Isn't." In *Systems of Care: Promising Practices in Children's Mental Health*, 1998 Series, Vol. 7. Rockville, MD: Child, Adolescent and Family Branch, Substance Abuse and Mental Health Service Administration.

White, J., and Parham, T. (1990). *The Psychology of Blacks: An African American Perspective*. Upper Saddle River, NJ: Prentice Hall.

Williams, C.L. (Ed.) (1987). *An Annotated Bibliography on Refugee Mental Health*. Rockville, MD: United States Department of Health and Human Services, Public Health Service, National Institute of Mental Health.

Organizations

The Action Council for Cross-Cultural Mental Health and Human Services, Inc.

The Action Council
P.O. Box 1695
Columbia, SC 29202
(803) 734-6475

The Action Council for Cross-Cultural Mental Health and Human Services, Inc. (ACCMHS) is a voluntary organization dedicated to enhancing the involvement of minority citizens in the management, delivery and utilization of mental health and human services. A dues-collecting, membership organization, the Action Council provides programmatic and policy consultation and training for managers and decision makers, and promotes education in understanding diverse cultures. The Action Council sponsors an annual conference in conjunction with the South Carolina Department of Mental Health and other sponsoring organizations.

The African American Family Services Technical Assistance Center

2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878

<http://www.aafs-mn.org>

Contact: Tasselean Parker

A division of a multi-faceted community-based agency offering mental health and chemical health services, the Technical Assistance Center creates training programs for counselors, agency administrators and boards of directors and other service professionals throughout the United States. Participants receive tools and techniques to enhance and improve service delivery to African American clients.

African American Mental Health Research Center

Institute for Social Research — Program for Research on Black Americans

University of Michigan
426 Thompson, Room 5118
Ann Arbor, MI 47106
(734) 763-0045

<http://www.isr.umich.edu/rcgd/prba>

The National Institute of Mental Health provided funding to help start this research center to study African American mental health issues and evaluate the way African Americans seek help for mental illness. The Center's interests include child and adolescent mental health and serious mental illness in urban areas.

American Counseling Association, Association for Multicultural Counseling and Development (AMCD)

P.O. Box 2256

Sacramento, CA 95812-2256

(916)424-8959

Contact: Dr. Marcelett Henry

Established in 1972 under the American Counseling Association, the AMCD works to develop an efficient and effective system of organizational management, enhance existing professional standards and promote and expand culturally competent research and knowledge.

American Psychological Association (APA)

Office of Ethnic Minority Affairs

750 First Street, NE

Washington, DC 20002-4242

(202) 336-5500

<http://www.apa.org/pi/oema/homepage.html>

The APA Office of Ethnic Minority Affairs (OEMA) seeks to promote scientific understanding of the influences of culture and ethnicity on behavior, encourage increased public knowledge of the special psychological resources and mental health needs of communities of color, and increase the number and participation of ethnic minority psychologists in the discipline and Association. In support of these objectives, OEMA's activities include maintaining and editing the *Directory of Ethnic Minority Professionals in Psychology*, operating a minority job bank and publishing *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*

American Psychological Association (APA)

Division 44, Gay and Lesbian Concerns

729 Boylston Street, 4th Floor

Boston, MA 02116

(617) 262-0315

<http://www.apa.org/about/division/div44.html>

Contact: Douglas M. Deville, PsyD

The APA Division 44, addressing gay and lesbian concerns, focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. It has task forces on accreditation, bisexuality, professional standards, public policy, youth and families, ethnic/racial issues, and science and research. Division 44 publishes a newsletter three times a year and a program describing Division 44's activities for distribution at the annual APA convention.

Asian and Pacific Islander Health Forum

942 Market Street, Suite 200

San Francisco, CA 94102

(415) 954-9988

<http://www.apiahf.org>

Contact: Tessie Guillermo

A national advocacy, policy and research organization dedicated to improving the health of Asian and Pacific Islander Americans. The Health Forum offers publications and fact sheets on all aspects of Asian and Pacific Islander health including mental health. The Forum also maintains a closed and moderated mailing list as an information and referral point for individuals and organizations that provide alcohol, substance abuse and mental health services.

Georgetown University Child Development Center

3307 M Street, NW

Washington, DC 20007

(202) 338-1831

<http://knsrv01.iaims.georgetown.edu/depts/pediatrics/gucdc>

Contact: Marva Benjamin, Director, Minority Initiative

The mission of the Georgetown University Child Development Center is to improve the quality of life for children with special needs and their families. Products and services include information packets, issue briefs and monographs on children and adolescents with serious emotional disturbances; conferences and training institutes on planning, delivery and financing of services; consultation on systems change and services development and delivery; and agency and organizational collaboration.

Lesbian, Gay, Bisexual and Transgender Health Access Project

JRI Health

100 Boylston Street, Suite # 860

Boston, MA 02116

(617)988-2605

Contact: Jan Platner

<http://www.glbthealth.org>

The Lesbian, Gay, Bisexual and Transgender Health Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual and transgender people through a variety of venues including community education, policy development, advocacy, direct service and prevention programs.

Multi-Ethnic Mental Health Consortium Resource and Training Center

17 S. High Street, Suite 1015

Columbus, OH 43215

(614) 228-2220

<http://www.mebhc.com>

Contact: Marty Miller

The Training Center provides advocacy and training on cultural diversity and mental health issues relevant to the needs of African American, Asian, Hispanic and Native American residents of Ohio.

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center, Department of Psychiatry

4455 East Twelfth Avenue, Campus Box A011-13

Denver, CO 80220

(303) 315-9232

<http://www.uchsc.edu/sm/ncaianmhr>

Contact: Spiro Manson, Ph.D. Director

Funded by the National Institute of Mental Health, the National Center for American Indian and Alaskan Native Mental Health Research focuses on research, research training, information dissemination and technical assistance for American Indian and Alaskan Native populations. The Center has developed a computerized bibliography on Indian and Alaskan Native mental health and a resource directory that inventories individuals, programs and agencies with expertise in mental health research, service and education specific to Indian and Alaskan Native communities.

The National Coalition of Hispanic Health and Human Services Organizations

1501 16th Street, NW

Washington, DC 20036

(202) 387-5000

<http://www.cossmho.org>

Contact: Jane Delgado, President

The Coalition is a nonprofit membership organization dedicated to improving the health and psychosocial well-being of the nation's Hispanic population by conducting national demonstration programs, coordinating research and providing information, technical assistance and policy analysis. More than 700 member organizations provide community-based health, mental health, substance abuse and social services.

National Council of La Raza (La Raza)

111 19th Street, NW, Suite 1000

Washington, DC 20036

(202) 785-1670

<http://www.nclr.org>

Contact: Helen Coronado

La Raza is a private, nonprofit organization established in 1968 to reduce poverty and discrimination and improve opportunities for Hispanic Americans. La Raza works toward this goal primarily through capacity-building assistance to support and strengthen Hispanic community-based organizations; applied research, policy analysis and advocacy' providing an Hispanic perspective on issues such as education, housing, and health; and encouraging the adoption of programs and policies that equitably serve Hispanics.

National MultiCultural Institute

3000 Connecticut Avenue, NW, Suite 438

Washington, DC 20008-2556

(202) 483-0700

<http://www.nmci.org>

Contact: Elizabeth Salett, President

A non-profit organization located in Washington, D.C., NMCI offers diversity training, sponsors multicultural conferences, produces educational resource materials and provides multicultural counseling and referral services.

National Research Center for Asian American Mental Health

Department of Psychology - University of California

One Shield Avenue

Davis, CA 95616-8686

(503) 752-1400

<http://psychology.ucdavis.edu/asianamerican/nrcaamh.html>

Contact: Stanley Sue, Ph.D.

Sponsored by the National Institute of Mental Health, the National Research Center for Asian American Mental Health conducts prevalence studies among Asian Americans and Pacific Islanders. The Center also studies mental health treatments, including assessment instruments and social networks.

Office of Minority Health Resource Center

P.O. Box 37337

Washington, DC 20013-7337

(800) 444-6472

TDD 301- 589-0951

<http://www.omhrc.gov>

The Minority Health Resource Center is a national resource and referral service for minority health issues that provides information on funding sources and community programs. The Center's newsletter, "Closing the Gap," is available free of charge. A customized data base searches health resources for African Americans, Asian Americans, Pacific Islanders, Latinos, and Native American populations.

Substance Abuse and Mental Health Service Administration (SAMHSA)**Pacific Islander Initiative**

Center for Substance Abuse Treatment

Suite 880, Rockwall II

5600 Fishers Lane

Rockville, MD 20857

(301)443-9396

<http://www.samhsa.gov>

SAMHSA collaborates with consumers and constituents, including Asian Americans and Pacific Islanders communities, to improve the quality and availability of prevention, treatment and rehabilitation services in order to reduce illness, death, disability and cost to society resulting from substance abuse and mental illnesses. Much of SAMHSA's work, service to, and communication with Asian Americans and Pacific Islanders has been through interactions with community-based groups and National organizations like the National Asian Pacific American Families Against Substance Abuse, Inc.(NAPAFASA), Asian and Pacific Islander American Health Forum, Inc.(APIAHF), Association of Asian/Pacific Community Health Organizations (AAPCHO), Asian Americans and Pacific Islanders for Health Promotion, Inc. (AAPIHPI), Asian American Prevention Cluster Group, Pacific Islands Officers Association and others.

Western Interstate Commission on Higher Education (WICHE)

Mental Health Program

P.O. Box 9752

Boulder, CO 80301-9752

(303) 541-0250

<http://www.wiche.edu>

Contact: Jim Stockdill, Ph.D.

WICHE is a public interstate agency established to promote and facilitate resource sharing, collaboration and cooperative planning among the western states for higher education and work force needs. Member and affiliate states include Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming.

Web Sites

APA Division 44, Gay and Lesbian Concerns

<http://www.apa.org/divisions/div44>

Focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. Division 44 has task forces on accreditation, bisexuality, professional standards, public policy, youth and families, ethnic/racial issues and science. The Division's web site includes information on human sexuality, answers to questions regarding sexual orientation and information on APA policies related to sexual minorities.

Asian Community Mental Health Services (ACMHS)

<http://www.acmhs.org>

ACMHS provides an array of culturally competent specialized services that include supportive behavioral health care services and substance abuse treatment and prevention services for at-risk youth. The organization's publications include educational brochures on prevention and clinical issues in several Asian languages.

Diversity Rx

<http://www.diversityrx.org>

Funded by the National Conference of State Legislatures, Resources for Cross Cultural Health Care and the Henry J. Kaiser Family Foundation of Menlo Park, CA, Diversity Rx seeks to educate health care providers, provide a repository of information and resources for anyone developing or promoting linguistically and culturally appropriate services, and to promote communication and information exchange among experts and others interested in the topic. The site includes demographic information, models and practices, policy information, and additional resources.

Indian Health Service

<http://www.ihs.gov>

As the federal agency that addresses the physical and mental health needs of Native Americans, the Indian Health Service hosts an Internet home page that provides information on the agency, helpful publications and links to other Native American-related web sites.

International Association for Cross-Cultural Psychology

<http://www.fit.edu/CampusLife/clubs-org/iaccp>

Founded in 1972 with membership of more than 500 professionals in more than 65 countries, IACCP aims to facilitate communication among persons interested in cross-cultural psychology and to examine more effectively the universal validity of psychological theories in all branches of psychology and related disciplines. Its web site contains information on IACCP's international congresses, regional meetings and relevant publications.

Lesbian, Gay, Bisexual and Transgender Health Access Project

<http://www.glbthealth.org>

The Lesbian, Gay, Bisexual and Transgender Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual and transgender people. Results of needs assessments, focus group research and newly developed standards of care are available on this web site.

NativeWeb

<http://www.nativeweb.org>

This comprehensive site describes its purpose as "providing a cyber-place for Earth's indigenous peoples." NativeWeb features information on many subject categories (including health and mental health), newsletters and journals, bibliographies and historical material.

Torture Survivors Network

<http://pacinfo.com/eugene/tsnet/index.html>

The Torture Survivors Network is a forum for survivors' voices, for exchange of information between treatment center professionals, for those interested in starting a program in their own community and for the general public. The Network's home page contains an information exchange, history of torture and survivors testimonies.

